ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

Health Services

Demographic and Consent Form AY26/27

Legal Name _____ Preferred Name _____ Pronouns _____

Date of Birth____ /___ /____ Student ID# _____ Email _____ Phone _____

Street Address _____ Residential Hall & Room_____

City _____ State _____ Zip Code _____

How may we reach you or leave a message? (check all that apply) ☐ Cell phone ☐ Campus email ☐ *Medicat* patient portal

Emergency Contact _____ Relationship _____

Phone Number #1 _____ #2 _____

Address_____

If you are incapacitated and unable to notify the emergency contact during your clinic visit, the Health Services staff will contact the individual listed above.

Consent for Treatment

I understand the information gathered by SMCM Health Services is confidential and will not be shared without my direct consent unless I am experiencing a medical or mental health emergency. If I require emergency treatment at SMCM Health Services or local hospitals and am unable to provide consent for treatment due to incapacitation, I hereby permit emergency medical treatment, including surgery, if deemed necessary and/or lifesaving by the provider rendering care.

If the patient is a minor, medical providers will attempt to contact the parent or guardian before rendering emergency medical treatment, including surgery, if deemed necessary and/or lifesaving.

If the patient is under the age of 18, a parent/guardian signature is required for treatment unless stipulated here:

Md. Code Ann., Health-Gen. II § 20-102

Maryland Minor Consent Laws

☐ I agree and consent to treatment.
☐ I have read and understand the Privacy Notice *(posted in the lobby and a paper copy is available upon request).*

Patient Signature _____ Date _____

Parent/Guardian Signature (if under 18) _____

Printed Name of Parent/Guardian _____Date _____